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ABSTRACT

Under the current Medicaid reimbursement system in Minnesota for intermediate care facilities for the mentally retarded (ICFs/MR), payments are not targeted properly because there is no uniform assessment and resource use information to determine those clients for whom services are most costly to provide. A project was mandated by the state legislature to determine whether an alternative system could help the state better target resources where need was greatest. An assessment instrument was developed and completed on 913 clients in 65 ICFs/MR. The assessment focused on resource use in the domains of special medical treatments, activities of daily living, challenging behaviors, and personal/community integration. The characteristics captured by the assessment instrument explain approximately 30% of the variation among clients in terms of staff resource usage. Assessment scores are used to determine service classifications for clients, which are then used to calculate daily program reimbursement rates. Because a significant amount of variation in resource use is not accounted for by the assessment instrument, the facility's cost report for the previous year is also considered in the rate setting process. Fifteen suggested readings are listed. (JDD)

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RESEARCH AND IMPLEMENTATION ISSUES IN DEVELOPING A REIMBURSEMENT SYSTEM FOR ICFs/MR PROGRAM COSTS BASED ON CLIENT RESOURCE USE.

Rosemary Chapin
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Introduction

The community service delivery system for persons with developmental disabilities has undergone significant expansion. This expansion has spurred states to reexamine their rate setting and reimbursement policies for these services to assure that rate determination methods reinforce, rather than impede the realization of key policy objectives. Such examination has led to concern that current methodologies do not target payments properly to those with the greatest need (Office of the Legislative Auditor, 1983). Payment methodologies for intermediate care facilities for the mentally retarded (ICFs/MR) have received particular scrutiny because Medicaid expenditures for ICFs/MR nationally have grown to over 5.5 billion dollars annually. This examination has reinforced concerns that these payments are not currently properly targeted.

In Minnesota, the state legislature mandated that the Commissioner of Human Services study alternative reimbursement systems for ICFs/MR. The purpose of the project was to determine whether an alternative system could help the state better target resources where need was greatest. This research has now been completed and Minnesota is planning to implement a new "client centered" method for setting Medicaid payment rates for ICFs/MR (Minnesota Department of Human Services, 1989).

Background

Under the current ICF/MR reimbursement system in Minnesota, payments are not targeted properly because there is no uniform assessment and resource use information to determine those clients for whom services are most costly to provide. Minnesota is committed to serving persons with developmental disabilities in community facilities rather than state-operated regional treatment centers (Office of the Legislative Auditor, 1986). As people with more intensive needs move from state-operated regional treatment centers and nursing homes into ICFs/MR, access problems are encountered because ICFs/MR do not want to take persons requiring intensive services if rates do not change to reflect the increased costs associated with delivery of those services.

When limits must be set, it is very difficult to do this equitably unless the resource use requirements of the clients of a particular facility are considered. Any limit figured off of the median of all facilities will penalize the facility providing services to people with high need and create very little incentive for efficiencies for a facility serving clients with very low needs.

In order to comply with a legislative mandate, the state contracted with the firm of Lewin-ICF to conduct research to develop a new reimbursement system that would target state resources more effectively. To assist in this study

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of alternative rate setting methods, an advisory committee consisting of advocates, providers, county directors, case managers, legislators, and other professionals in the field was appointed. Staff from the Department of Human Services (DHS) Developmental Disabilities Program Division, Long-Term Care Management Division, and the Departments of Health (MDH) and Finance also were involved in this study.

Throughout the research project, DHS staff and contractors have met regularly with county directors, social service supervisors, Minnesota Department of Health staff, providers, advocates, and legislators to keep them informed and to receive input.

The Research

The ICF/MR reimbursement research included the following components:

- A review and analysis of other states' methods (and proposed methods) for setting ICF/MR rates linked to the assessed needs of clients.

- An analysis of 1984 Minnesota Department of Health Quality Assurance and Review assessment data and ICF/MR cost report information to describe and try to explain variations among ICFs/MR in costs. This study found extremely wide variations among facilities and very little to explain those variations, except that facilities with more staff had higher costs.

- A mini-study was conducted in 20 facilities (10 higher cost, 10 lower cost) in order to better understand why program costs varied and to determine whether it was feasible to proceed with efforts to design a reimbursement system related to assessed client needs and services. It was generally found that specific client characteristics, falling into four basic domains, substantially contributed to variations in need for staff time. These domains were: extraordinary/disabling physical conditions, need for help with activities of daily living (ADLs), degree of activity to promote personal interaction/community integration, and challenging behaviors.

One observation from the "mini-study" was that there are fewer predictable associations between resource use (staff time) and measurable characteristics of ICF/MR clients than are typically found between resource use and other studied groups (i.e., nursing home residents). The reason for this is that ICF/MR clients must receive "active treatment." The "need" for or "capacity to consume" active treatment, as in all education programs, is essentially boundless. The initial observation from the mini-study was further confirmed empirically in the detailed time study subsequently conducted by DHS. As a result, the system developed was not a "case-mix" reimbursement system in the classical sense. Rather, the system of assessments, groups, and weights emphasized services needed and received.

The final major step of the study was an empirical study of the relationship between staff time and types and intensity of staff assistance with ICF/MR clients. An extensive assessment instrument was developed, encompassing multiple items in each of the domains identified as important in the mini-study. An assessment instrument was completed on 913 clients in a stratified random sample of 65 ICFs/MR.

For each study client, a "relative resource use score" (RRU) was constructed using information about the type, amount, and cost of staff time spent on the client.

Each client's relative resource use (RRU) score was linked to his or her assessment data. The relationship between each item on the assessment instrument and the relative amount of staff time (the RRU score) was analyzed. In brief, we found:

- The best predictor of the amount of staff time a person receives is specific facility in which he or she lives.

- The characteristics captured by the assessment instrument do explain a reasonable, though modest amount of the variation among clients in staff resources. The proposed model explains approximately 30% of the variation.

- In every domain (special medical treatments, ADLs, challenging behaviors, personal/community integration), the association between staff time/resources and client characteristics/services are in the predicted direction.

- The strongest predictor of resource use are clients needs in activities of daily living, particularly the basic ADLs (bathing, eating, toileting, grooming, dressing).

Based on analysis of the linked assessment and resource use data, a Service Group classification system was developed. Each Service Group has an associated "weight," which was derived from the average RRU score of clients in that service group in the time study. These weights are used to compute the service units for each facility. (See Exhibit 1 on p. 6.)

The Proposed ICF/MR System

In linking the reimbursement system to the resource use findings, several factors had to be considered.

- First, preliminary research confirmed that it was program costs that showed variation given heavier care needs of clients. The research study targeted program costs and therefore, only the program component of the rate will vary with the resource use of the clients. Rates for property costs will not be affected.

- Second, approximately 83% of the facilities in Minnesota have under 16 beds, and 53% have 10 or fewer beds.

- Revenue fluctuation for small facilities may be difficult to absorb especially if the rate is subject to change at numerous assessment points.

Under the proposed system, all clients residing in ICFs/MR will be assessed annually by the Minnesota Department of Health beginning January 1989. New clients will be assessed within 30 days of admission by county case managers beginning January 1989. The assessment to be used is based on the original research assessment instrument. It was developed with major consultation from the Minnesota Department of Health, providers, and county case managers. Case managers across the state also piloted the assessment before implementation. Clients will then receive service classifications based on their assessment scores. These service classifications are used to determine service units provided by the facility.

The prospective facility rate per service unit will be determined annually based on the facility cost report for the previous reporting year and the service units provided during that calendar year. Each facility's expenditures for program costs (direct care salaries, benefits, supplies, and behaviorally related repairs) in calendar year 1989 will be divided by the facility's service units for the same period of time, to determine how much the facility spends, relative to the intensity of client needs and programming.

In order to calculate the daily programs rates the classifications of the facility clients at the time of the latest assessment will be utilized. Number of clients at each weight will be multiplied by the weight and then summed to determine total daily service units. Average daily service units will be multiplied by the daily service unit rate to determine the daily program payment rates. Daily program payment rates could change when the client service needs change or when one client leaves and is replaced by another with different service needs.

Implementation Issues

Documentation

Documentation of client services needed and received by the ICF/MR has been a major issue in implementing the new system. When Quality Assurance and Review (QAR) teams from the Department of Health examined client records to complete assessments, specific documentation of needs and services necessary to complete the assessment, was, in some instances lacking, or difficult to find. For example, results of the 1989 (QAR) assessments indicated only a fraction of the clients had documentation indicating they were receiving intensive personal interaction, independence and integration services. This was far less than initial staff estimates.

A training contract designed to help providers develop simple but adequate documentation programs is currently being implemented. Documentation requirements are being examined by a group comprised of providers, and Departments of Human Services and Health staff, for ways to simplify documentation and solve the documentation problem.

Fiscal Impact

Costs for the new system include the amount necessary to adjust program costs to align some facilities costs with other facilities found to be caring for clients with similar service needs under the new client classification system, yet which have historically low rates. The number of facilities receiving an adjustment will determine the costs. There will also be increased administrative costs for implementation at the state level which are estimated at $100,000 annually. The assessment, reconsideration, and processing system necessary to implement this new system builds on current Department of Health operations which lessens additional costs. An additional cost to the state, which has been difficult to estimate, is possible increased costs due to facility documentation improvements between the assessment used to determine rates and later assessments during the rate year.

The expected fiscal impact on counties is their proportionate share of Medical Assistance cost, which is approximately 4.75 percent. County case managers will also be completing assessments for reimbursement purposes in certain cases, which will be an additional county cost. Facilities may have additional costs for documentation, depending on their current methods.

Special Considerations

Although the proposed system will target resources more effectively than the current system, there will still be people with special needs who may require additional resources. Proposals to address these needs include a time limited special needs rate. Also being considered is a habilitation incentive to encourage intensive work with people which results in discharge to a less restrictive environment.

EXHIBIT 1

DEFINITIONS AND WEIGHTS FOR SERVICE/NEED LEVELS

Service/Need Level	ADL's	Challenging Behaviors	Community Integration	Service Unit Weight
1 o Standard	Low (0 - 1)	Low (Under 90)	S Under 90	1.00
o Intensive			I = 90+	1.04
2 o Standard		High (90+)	S Under 90	1.36
o Intensive			I = 90+	1.52
3 o Standard	Medium (2 - 5)	Low (Under 90)	S Under 90	1.58
o Intensive			I = 90+	1.68
4 o Standard		High (90+)	S Under 90	1.87
o Intensive			I = 90+	2.02
5 o Standard	High (6 - 9)	Low (Under 90)	S Under 90	2.09
o Intensive			I = 90+	2.26
6 o Standard		High (90+)	S Under 90	2.26
o Intensive			I = 90+	2.52
7 o Standard	NA* Medically Complex	NA*	S Under 90	2.10
o Intensive			I = 90+	2.37

* Not Applicable

Suggested Readings

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Abstract

This article describes the impetus, research, and recommendations for a new reimbursement system based on client resource use for ICFs/MR in Minnesota. Research to develop this method for targeting reimbursement in ICFs/MR/ has been completed and a proposal for basing program rates on client resource use has been developed. Nine hundred thirteen residents in a stratified sample of 65 facilities were assessed and staff resource use was determined. It was found that although predictors in the area of personal interaction, integration, and independence, activities of daily living, special treatment/medical complexity, and behavior accounted for a significant amount of variation in resource use, the amount of unaccounted for variation was sufficiently large to support recommending a system which will base program rates on individual client resource use and the historical costs of individual facilities. Key administrative and design issues are also discussed.

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